GENERAL LEAVE

Mr. THOMAS. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and include extraneous material on the subject of House Joint Resolution 97.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from California?

There was no objection.

□ 1515

STROKE TREATMENT AND ONGOING PREVENTION ACT

Mr. PICKERING. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 3658) to amend the Public Health Service Act to strengthen education, prevention, and treatment programs relating to stroke, and for other purposes, as amended.

The Clerk read as follows:

H.R. 3658

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Stroke Treatment and Ongoing Prevention Act''.

SEC. 2. AMENDMENTS TO PUBLIC HEALTH SERVICE ACT REGARDING STROKE PROGRAMS.

(a) STROKE EDUCATION AND INFORMATION PROGRAMS.—Title III of the Public Health Service Act (42 U.S.C. 241 et seq.) is amended by adding at the end the following:

''PART R—STROKE EDUCATION, INFORMATION, AND DATA COLLECTION PROGRAMS

''SEC. 399AA. STROKE PREVENTION AND EDUCATION CAMPAIGN.

''(a) IN GENERAL.—The Secretary shall carry out an education and information campaign to promote stroke prevention and increase the number of stroke patients who seek immediate treatment.

''(b) AUTHORIZED ACTIVITIES.—In implementing the education and information campaign under subsection (a), the Secretary may—

''(1) make public service announcements about the warning signs of stroke and the importance of treating stroke as a medical emergency;

''(2) provide education regarding ways to prevent stroke and the effectiveness of stroke treatment; and

''(3) carry out other activities that the Secretary determines will promote prevention practices among the general public and increase the number of stroke patients who seek immediate care.

''(c) MEASUREMENTS.—In implementing the education and information campaign under subsection (a), the Secretary shall—

''(1) measure public awareness before the start of the campaign to provide baseline data that will be used to evaluate the effectiveness of the public awareness efforts;

''(2) establish quantitative benchmarks to measure the impact of the campaign over time; and

''(3) measure the impact of the campaign not less than once every 2 years or, if determined appropriate by the Secretary, at shorter intervals.

''(d) NO DUPLICATION OF EFFORT.—In carrying out this section, the Secretary shall avoid duplicating existing stroke education efforts by other Federal Government agencies.

''(e) CONSULTATION.—In carrying out this section, the Secretary may consult with organizations and individuals with expertise in stroke prevention, diagnosis, treatment, and rehabilitation.

''SEC. 399BB. PAUL COVERDELL NATIONAL ACUTE STROKE REGISTRY AND CLEARINGHOUSE.

''The Secretary, acting through the Centers for Disease Control and Prevention, shall maintain the Paul Coverdell National Acute Stroke Registry and Clearinghouse by—

''(1) continuing to develop and collect specific data points and appropriate benchmarks for analyzing care of acute stroke patients;

''(2) collecting, compiling, and disseminating information on the achievements of, and problems experienced by, State and local agencies and private entities in developing and implementing emergency medical systems and hospital-based quality of care interventions; and

''(3) carrying out any other activities the Secretary determines to be useful to maintain the Paul Coverdell National Acute Stroke Registry and Clearinghouse to reflect the latest advances in all forms of stroke care.

''SEC. 399CC. STROKE DEFINITION.

''For purposes of this part, the term 'stroke' means a 'brain attack' in which blood flow to the brain is interrupted or in which a blood vessel or aneurysm in the brain breaks or ruptures.

''SEC. 399DD. AUTHORIZATION OF APPROPRIATIONS.

''There is authorized to be appropriated to carry out this part $5,000,000 for each of fiscal years 2005 through 2009.''.

(b) EMERGENCY MEDICAL PROFESSIONAL DEVELOPMENT.—Section 1251 of the Public Health Service Act (42 U.S.C. 300d–51) is amended to read as follows:

''SEC. 1251. MEDICAL PROFESSIONAL DEVELOPMENT IN ADVANCED STROKE AND TRAUMATIC INJURY TREATMENT AND PREVENTION.

''(a) RESIDENCY AND OTHER PROFESSIONAL TRAINING.—The Secretary may make grants to public and nonprofit entities for the purpose of planning, developing, and enhancing approved residency training programs and other professional training for appropriate health professions in emergency medicine, including emergency medical services professionals, to improve stroke and traumatic injury prevention, diagnosis, treatment, and rehabilitation.

''(b) CONTINUING EDUCATION ON STROKE AND TRAUMATIC INJURY.—

''(1) GRANTS.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, may make grants to qualified entities for the development and implementation of education programs for appropriate health care professionals in the use of newly developed diagnostic approaches, technologies, and therapies for health professionals involved in the prevention, diagnosis, treatment, and rehabilitation of stroke or traumatic injury.

''(2) DISTRIBUTION OF GRANTS.—In awarding grants under this subsection, the Secretary shall give preference to qualified entities that will train health care professionals that serve areas with a significant incidence of stroke or traumatic injuries.

''(3) APPLICATION.—A qualified entity desiring a grant under this subsection shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including a plan for the rigorous evaluation of activities carried out with amounts received under the grant.

''(4) DEFINITIONS.—For purposes of this subsection:

''(A) The term 'qualified entity' means a consortium of public and private entities, such as universities, academic medical centers, hospitals, and emergency medical systems that are coordinating education activities among providers serving in a variety of medical settings.

''(B) The term 'stroke' means a 'brain attack' in which blood flow to the brain is interrupted or in which a blood vessel or aneurysm in the brain breaks or ruptures.

''(c) REPORT.—Not later than 1 year after the allocation of grants under this section, the Secretary shall submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a report on the results of activities carried out with amounts received under this section.

''(d) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $4,000,000 for each of fiscal years 2005 through 2009. The Secretary shall equitably allocate the funds authorized to be appropriated under this section between efforts to address stroke and efforts to address traumatic injury.''.

SEC. 3. PILOT PROJECT ON TELEHEALTH STROKE TREATMENT.

(a) ESTABLISHMENT.—Part D of title III of the Public Health Service Act (42 U.S.C. 254b et seq.) is amended by inserting after section 330L the following:

''SEC. 330M. TELEHEALTH STROKE TREATMENT GRANT PROGRAM.

''(a) GRANTS.—The Secretary may make grants to States, and to consortia of public and private entities located in any State that is not a grantee under this section, to conduct a 5-year pilot project over the period of fiscal years 2005 through 2009 to improve stroke patient outcomes by coordinating health care delivery through telehealth networks.

''(b) ADMINISTRATION.—The Secretary shall administer this section through the Director of the Office for the Advancement of Telehealth.

''(c) CONSULTATION.—In carrying out this section, for the purpose of better coordinating program activities, the Secretary shall consult with—

''(1) officials responsible for other Federal programs involving stroke research and care, including such programs established by the Stroke Treatment and Ongoing Prevention Act; and

''(2) organizations and individuals with expertise in stroke prevention, diagnosis, treatment, and rehabilitation.

''(d) USE OF FUNDS.—

''(1) IN GENERAL.—The Secretary may not make a grant to a State or a consortium under this section unless the State or consortium agrees to use the grant for the purpose of—

''(A) identifying entities with expertise in the delivery of high-quality stroke prevention, diagnosis, treatment, and rehabilitation;

''(B) working with those entities to establish or improve telehealth networks to provide stroke treatment assistance and resources to health care professionals, hospitals, and other individuals and entities that serve stroke patients;

''(C) informing emergency medical systems of the location of entities identified under subparagraph (A) to facilitate the appropriate transport of individuals with stroke symptoms;

''(D) establishing networks to coordinate collaborative activities for stroke prevention, diagnosis, treatment, and rehabilitation;

''(E) improving access to high-quality stroke care, especially for populations with a shortage of stroke care specialists and populations with a high incidence of stroke; and

''(F) conducting ongoing performance and quality evaluations to identify collaborative activities that improve clinical outcomes for stroke patients.

''(2) ESTABLISHMENT OF CONSORTIUM.—The Secretary may not make a grant to a State under this section unless the State agrees to establish a consortium of public and private entities, including universities and academic medical centers, to carry out the activities described in paragraph (1).

''(3) PROHIBITION.—The Secretary may not make a grant under this section to a State that has an existing telehealth network that is or may be used for improving stroke prevention, diagnosis, treatment, and rehabilitation, or to a

consortium located in such a State, unless the State or consortium agrees that—

''(A) the State or consortium will use an existing telehealth network to achieve the purpose of the grant; and

''(B) the State or consortium will not establish a separate network for such purpose.

''(e) PRIORITY.—In selecting grant recipients under this section, the Secretary shall give priority to any applicant that submits a plan demonstrating how the applicant, and where applicable the members of the consortium described in subsection (d)(2), will use the grant to improve access to high-quality stroke care for populations with shortages of stroke-care specialists and populations with a high incidence of stroke.

''(f) GRANT PERIOD.—The Secretary may not award a grant to a State or a consortium under this section for any period that—

''(1) is greater than 3 years; or

''(2) extends beyond the end of fiscal year 2009.

''(g) RESTRICTION ON NUMBER OF GRANTS.—In carrying out the 5-year pilot project under this section, the Secretary may not award more than 7 grants.

''(h) APPLICATION.—To seek a grant under this section, a State or a consortium of public and private entities shall submit an application to the Secretary in such form, in such manner, and containing such information as the Secretary may require. At a minimum, the Secretary shall require each such application to outline how the State or consortium will establish baseline measures and benchmarks to evaluate program outcomes.

''(i) DEFINITION.—In this section, the term 'stroke' means a 'brain attack' in which blood flow to the brain is interrupted or in which a blood vessel or aneurysm in the brain breaks or ruptures.

''(j) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $10,000,000 for fiscal year 2005, $13,000,000 for fiscal year 2006, $15,000,000 for fiscal year 2007, $8,000,000 for fiscal year 2008, and $4,000,000 for fiscal year 2009.''.

(b) STUDY; REPORTS.—

(1) FINAL REPORT.—Not later than March 31, 2010, the Secretary of Health and Human Services shall conduct a study of the results of the telehealth stroke treatment grant program under section 330M of the Public Health Service Act (added by subsection (a)) and submit to the Congress a report on such results that includes the following:

(A) An evaluation of the grant program outcomes, including quantitative analysis of baseline and benchmark measures.

(B) Recommendations on how to promote stroke networks in ways that improve access to clinical care in rural and urban areas and reduce the incidence of stroke and the debilitating and costly complications resulting from stroke.

(C) Recommendations on whether similar telehealth grant programs could be used to improve patient outcomes in other public health areas.

(2) INTERIM REPORTS.—The Secretary of Health and Human Services may provide interim reports to the Congress on the telehealth stroke treatment grant program under section 330M of the Public Health Service Act (added by subsection (a)) at such intervals as the Secretary determines to be appropriate.

SEC. 4. RULE OF CONSTRUCTION.

Nothing in this Act shall be construed to authorize the Secretary of Health and Human Services to establish Federal standards for the treatment of patients or the licensure of health care professionals.

The SPEAKER pro tempore (Mr. PETRI). Pursuant to the rule, the gentleman from Mississippi (Mr. PICKERING) and the gentleman from Ohio (Mr. BROWN) each will control 20 minutes.

The Chair recognizes the gentleman from Mississippi (Mr. PICKERING).

GENERAL LEAVE

Mr. PICKERING. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks on this legislation and to insert extraneous material on the bill.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Mississippi?

There was no objection.

Mr. PICKERING. Mr. Speaker, I yield myself such time as I may consume.

As one of the sponsors of this bill and serving on the Committee on Energy and Commerce, I would like to begin by commending all those who have worked to bring this legislation to the House floor. I would like to extend a special thanks to my colleague and sponsor, the gentlewoman from California (Mrs. CAPPS), as well as Committee on Energy and Commerce Chairman, the gentleman from Texas (Mr. BARTON); subcommittee chairman, the gentleman from Florida (Mr. BILIRAKIS); subcommittee ranking member, the gentleman from Ohio (Mr. BROWN), and committee staff for their tireless efforts to move this important legislation.

As a personal point of privilege, I would like to commend my staff Mary Mills Lane and before her Jason Dedwylder for their long and good work on this legislation.

Despite significant advances in the diagnosis, treatment and prevention, stroke remains the Nation's No. 3 killer and a leading cause of long-term disability. According to the American Heart Association, on the average every 45 seconds someone in the United States has a stroke. Every year 700,000 Americans suffer a stroke, and 164,000 lose their lives. My home State of Mississippi ranks seventh highest in terms of death rates from stroke. Approximately 2,000 individuals in Mississippi alone lost their lives to stroke in 2000.

Not only are individuals losing their lives, but today 4.7 million Americans are stroke survivors, and as many as 30 percent are permanently disabled, requiring extensive and costly care. It is expected that strokes will cost the Nation $53.6 billion in 2004, including $33 billion in direct costs and $20.6 billion in indirect costs.

Prompt treatment of patients experiencing stroke can save lives and reduce disability, yet thousands of stroke patients do not receive the care they need.

Additionally, most Americans cannot identify the signs of stroke, and even emergency medical technicians are often not taught how to recognize and manage the symptoms. Even in hospitals, stroke patients often do not receive the care that could save their lives.

The STOP Stroke Act is the first step to removing these barriers to quality stroke care in order to save lives and reduce disability.

This legislation addresses a number of significant barriers to quality stroke care, including low public awareness, lack of necessary infrastructure, low awareness among medical professionals and a lack of adequate data collection.

This bill authorizes a national public information campaign to educate the public about stroke, how to reduce risk, recognize the warning signs and seek emergency treatment as soon as symptoms occur.

This legislation also authorizes the Paul Coverdell Stroke Registry and Clearinghouse to collect data about the care of acute stroke patients and foster the development of effective stroke care systems.

The clearinghouse will serve as a resource for States seeking to design and implement their own stroke care. It will help build systems to collect, analyze and disseminate information and will build on the efforts of other communities to establish similar systems.

The STOP Stroke Act will provide grants for public and nonprofit entities to develop and implement continuing education programs and the use of new diagnostic approaches, technologies and therapies for the prevention and treatment of stroke.

Finally, this bill authorizes a telehealth stroke treatment pilot project to support States' efforts to develop comprehensive networks to improve stroke prevention, treatment and rehabilitation. These grants will allow States to identify stroke centers, improve communications networks that bring stroke care to rural areas and decrease response time.

The time has come for a bill to stop the incidences, the high rates of stroke. This bill is past due. We are in a situation where stroke rates are on the rise, and we must now act to address the issues that are going to help us match resources with the growing need to prevent and treat this devastating illness.

I look forward to working with my colleagues in the Senate to properly move similar legislation that previously passed by unanimous consent in the last Congress. I urge my House colleagues to vote for this bill.

And as a point of personal privilege, I want to commend all of this work, my own work, to the memory of my grandparents, my mama and papa, my papa suffered from a stroke, and all those family members all across this country who have lost someone to a stroke and have watched their family care and love those who have been affected. I hope that this can help provide the resources and the information as all the country comes together to help those, first to prevent stroke and to care for those who have been the victims of stroke.

Mr. Speaker, I reserve the balance of my time.

Mr. BROWN of Ohio. Mr. Speaker, I yield 4 minutes to myself.

Mr. Speaker, I want to begin by thanking my colleagues, the gentlewoman from California (Mrs. CAPPS),

who is a registered nurse and who has been a leader in this body in health care, and the gentleman from Mississippi (Mr. PICKERING). Because of their leadership, we have the opportunity to pass legislation today that can prevent disability and save lives.

I would like to commend majority counsel Cheryl Jaeger for her good work and minority counsel John Ford for his good work on this bill.

Stroke, as we know, is the third leading cause of death in this country and a major cause of severe, long-term disability. Though stroke affects all kinds of Americans, stroke death rates are substantially higher for African Americans. An effective response to stroke, therefore, is an important opportunity to address the troubling health disparities that we see in this country all too often. In all, about 700,000 Americans will have a stroke this year. That is one every 45 seconds. A stroke will kill one American every 3 minutes.

Perhaps the most disheartening fact, however, is that this suffering is largely preventable. Early detection drastically reduces the harm from stroke. The risk of paralysis and other disabilities is reduced by 30 percent if stroke victims are detected within the first 3 hours. Unfortunately, only 10 percent of stroke victims are treated in this time period in part because only one of five Americans can readily identify the symptoms of a stroke.

In a health care symptom as sophisticated as ours, as high tech as ours, this is certainly simply not acceptable. The Stroke Treatment and Ongoing Protection Act will provide the public with the information necessary to recognize early signs of stroke and drastically reduce the chance of disability or death. The bill will educate medical personnel to help them improve their diagnosis and treatment of stroke victims, and it will help States develop a network to improve stroke prevention and treatment and rehabilitation.

EMTs, doctors and nurses have helped close to 5 million people survive a stroke. A strong network of advocates led by the American Heart Association has helped millions more take the steps necessary to reduce their risk of having a stroke. The Stroke Treatment and Ongoing Prevention Act would strengthen these efforts and help us fight this debilitating and deadly disease.

I urge my colleagues to support this important bill.

Mr. Speaker, I reserve the balance of my time.

Mr. PICKERING. Mr. Speaker, I yield such time as he may consume to the gentleman from Georgia (Mr. BURNS).

Mr. BURNS. Mr. Speaker, I rise today in support of H.R. 3658, the Stroke Treatment and Ongoing Prevention Act of 2004. Thousands of American families have had their lives touched by the tragedy of stroke. In July of 2000, the entire State of Georgia was affected when we lost our senior Senator John Coverdell.

According to the American Heart Association, another American experiences a stroke every 45 seconds. Every 45 seconds another American faces the possibility of mental impairment, paralysis or death. The STOP Stroke Act will establish a campaign to teach Americans about the risk and signs of stroke so that more incidents may be prevented and so that more victims may receive important and timely care. This bill also recognizes the importance of our research community and directs the Secretary of Health and Human Services to assist them in their work by maintaining the Paul Coverdell National Acute Registry and Clearinghouse with information and statistics useful to both research and caregivers.

Mr. Speaker, I am pleased to offer my support for H.R. 3658 and I look forward to casting my vote in favor of this legislation and of the stroke victims both in Georgia and throughout the United States.

Mr. BROWN of Ohio. Mr. Speaker, I yield 5 minutes to the gentlewoman from California (Mrs. CAPPS).

Mrs. CAPPS. Mr. Speaker, I thank the gentleman from Ohio (Mr. BROWN) for yielding me time.

Mr. Speaker, it is important that the House of Representatives is considering the Stroke Treatment and Ongoing Prevention Act, or STOP Stroke Act, today. As my colleague from Mississippi has just said, this bill is past due and it is time for us to act today.

Right now stroke is the number three killer in the United States and it is one of the major causes of serious disability. Each year more than 700,000 Americans suffer from a stroke, as has been said, and 170,000 people die from a stroke every year.

Of national significance, nearly 4½ million Americans are stroke survivors today, at tremendous cost personally to families, to all of us. And as has been said, this is a very personal story. Whether it is Senator Coverdell or my father-in-law, each of us is involved in the story of stroke. But what makes this so heartbreaking is the fact that many of these deaths and disabilities can be prevented with the treatments available today.

As cochair of the Congressional Heart and Stroke Coalition, it is our goal to improve that disparity. If a stroke victim can get quick treatment within 2 to 3 hours of the onset of symptoms lives can be saved and many disabilities can be avoided or curtailed. But fewer than 3 percent of stroke patients now receive the state of the art medication, and only one in 10 stroke patients are monitored by a neurologist. Sadly and tragically, most Americans cannot today identify the signs of strokes, and many emergency room technicians are not trained to recognize and manage its symptoms. That is why I am proud to introduce the Stroke Treatment and Ongoing Prevention Act, or STOP Stroke Act, and I am so pleased to work with my colleague, the gentleman from Mississippi (Mr. PICKERING).

I am very proud also to be associated with the work of Senator COCHRAN, Senator FRIST and Senator KENNEDY on this important legislation. The bill creates a stroke prevention and education campaign. This campaign, much needed, will be a national multi-media awareness effort to promote stroke prevention and encourage stroke patients to seek immediate treatment. We will also establish the Paul Coverdell Stroke Registry and Clearinghouse in the law, and this program will collect data about care for stroke patients and foster the development of effective stroke care systems, streamlining the response time and the response efforts.

The bill provides for medical professional development to make sure our health care providers are up to date on the newest and best treatments and technologies.

And finally, the STOP Stroke Act creates a pilot program to provide grants for Statewide stroke care systems, so that States can develop and implement stroke prevention, treatment and rehabilitation systems. The various States then would be able to use these resources to improve telehealth programs, train emergency medical services personnel, identify stroke care, treatment, and rehabilitation centers and create a system to set standards of care for stroke patients and develop and evaluate their stroke care systems.

Passing this bill will be a great step forward for stroke care in this country. It has the potential to help millions of Americans avoid stroke and/or better cope with its effects. It is a good example of what bipartisan negotiation and compromise can accomplish.

I want to take a moment to thank the gentleman from Mississippi (Mr. PICKERING) for this leadership on this issue. He and his staff have been strong partners in this effort. I want to thank the gentleman from Texas (Mr. BARTON) for his early support, as well as the former chairman, the gentleman from Louisiana (Mr. TAUZIN), the gentleman from Florida (Mr. BILIRAKIS) and the ranking members, the gentleman from Michigan (Mr. DINGELL) and the gentleman from Ohio (Mr. BROWN) for all their efforts on this bill's behalf.

I make a point of thanking our counsel Cheryl Jaeger on the gentleman from Texas' (Mr. BARTON) staff and counsel John Ford on the gentleman from Michigan's (Mr. DINGELL) staff, and my own staff member Jeremy Sharp for the many hours of work put into this effort.

It is very important I believe to thank the American Heart Association, the American Stroke Association and the many members of the STOP Stroke Act Coalition for their efforts to get this passed. The members are as follows:

American Academy of Neurology
American Academy of Physical Medicine and Rehabilitation

American Association of Neurological Surgeons
American College of Chest Physicians
American College of Emergency Physicians
American College of Preventive Medicine
American College of Radiology
American Heart Association/American Stroke Association
American Occupational Therapy Association
American Physical Therapy Association
American Society of Interventional and Therapeutic Neuroradiology
American Society of Neuroradiology
Association of American Medical Colleges
Associaiton of State and Territorial Chronic Disease Program Directors
Association of State and Territorial Directors of Health
Promotion and Public Health Education
Boston Scientific
Brain Injury Association, Inc.
Congres of Neurological Surgeons
Emergency Nurses Association
Genentech, Inc.
Johnson & Johnson
National Association of Public Hospitals and Health Systems
National Stroke Association
North American Society of Pacing and Electrophysiology
Partnership for Prevention
Society of Cardiovascular and Interventional Radiology
Stroke Belt Consortium

It underscores for us all that there is cooperation within the constituency of health care providers and now it is time for us to become partners in this effort.

I urge my colleagues to pass this bill and move this process forward.

Mr. DINGELL. Mr. Speaker, I rise in support of H.R. 3658, the ''Stroke Treatment and Ongoing Prevention Act.'' Stroke is the third leading cause of death in America and is a major contributor to long-term disability. Timely diagnosis and treatment of strokes is crucial. Outcomes forthose who receive care within the first few hours of a stroke at facilities with highly trained health care professionals are dramatically improved over those who receive treatment later. According to the American Heart Association, approximately 700,000 Americans suffer from stroke each year and 170,000 die from stroke.

This bill will help reduce premature death and disability from stroke in several ways. First, H.R. 3658 will authorize stroke prevention and treatment education and information programs for the public and health professionals. Second, this bill strengthens and improves the Paul Coverdell National Acute Registry and Clearinghouse, an important source of information on sroke incidence and outcomes. Third, H.R. 3658 authories grants for residence training programs and appropriate training of other health professions in emergency medicine to improve stroke and traumatic injury prevention, diagnosis, treatment, and rehabilitation. Finally, this bill establishes a five-year pilot project aimed at improving stroke patient outcomes by coordinating health care delivery through telehealth networks.

Mr. Speaker, I want to thank my distinguished colleagues, Chairman BARTON, Chairman BILIRAKIS, and Subcommittee on Health Ranking Member BROWN for their leadership on this matter. I particularly want to thank Representative CAPPS for her hard work and dedication to the issue of stroke prevention and treatment. Representative CAPPS has once again demonstrated her effectiveness and tireless effort on behalf of the health of our nation. She is a thoughtful legislator and skillful negotiator and I give her much of the credit for making today possible.

I urge all of my colleagues to support this bill.

Mr. BROWN of Ohio. Mr. Speaker, I have no further requests for time, and I yield back the balance of my time.

Mr. PICKERING. Mr. Speaker, I have no further requests for time, and I yield back the balance of my time.

The SPEAKER pro tempore (Mr. PETRI). The question is on the motion offered by the gentleman from Mississippi (Mr. PICKERING) that the House suspend the rules and pass the bill, H.R. 3658, as amended.

The question was taken; and (two-thirds having voted in favor thereof) the rules were suspended and the bill, as amended, was passed.

A motion to reconsider was laid on the table.

□ 1530

EXPRESSING SENSE OF CONGRESS WITH RESPECT TO NEED TO PROVIDE PROSTATE CANCER PATIENTS WITH MEANINGFUL ACCESS TO INFORMATION ON TREATMENT OPTIONS

Mr. DEAL of Georgia. Mr. Speaker, I move to suspend the rules and agree to the resolution (H. Res. 669) expressing the sense of Congress with respect to the need to provide prostate cancer patients with meaningful access to information on treatment options, and for other purposes.

The Clerk read as follows:

H. RES. 669

Whereas, in 2004, it is estimated that approximately 230,000 new cases of prostate cancer will be diagnosed in the United States, and nearly 30,000 men in the United States will die from prostate cancer;

Whereas prostate cancer is the second leading cause of cancer death in men in the United States;

Whereas over $4,700,000,000 is spent annually in the United States in direct treatment costs for prostate cancer;

Whereas African American men are diagnosed with and die from prostate cancer more frequently than men of other ethnic backgrounds;

Whereas increased education among health care providers and patients regarding the need for prostate cancer screening tests has resulted in the diagnosis of approximately 86 percent of prostate cancer patients before the cancerous cells have spread appreciably beyond the prostate gland, thereby enhancing the odds of successful treatment;

Whereas the potential complication rates for significant side effects vary among the most common forms of treatment for prostate cancer;

Whereas prostate cancer often strikes elderly people in the United States, highlighting the importance of balancing the potential benefits and risks of various treatments on an individual basis; and

Whereas Congress as a whole, and Members of Congress as individuals, are in unique positions to support the fight against prostate cancer, to help raise public awareness about the need to make screening tests available to all people at risk for prostate cancer, and to provide prostate cancer patients with adequate information to assess the relative benefits and risks of treatment options: Now, therefore, be it

Resolved, That it is the sense of the House of Representatives that—

(1) national and community organizations and health care providers have played a commendable role in supplying information concerning the importance of screening for prostate cancer and the treatment options for patients with prostate cancer; and

(2) the Federal Government and the States should ensure that health care providers supply prostate cancer patients with appropriate information and any other tools necessary for prostate cancer patients to receive readily understandable descriptions of the advantages, disadvantages, benefits, and risks of all medically efficacious treatments for prostate cancer, including brachytherapy, hormonal treatments, external beam radiation, chemotherapy, surgery, and watchful waiting.

The SPEAKER pro tempore (Mr. PETRI). Pursuant to the rule, the gentleman from Georgia (Mr. DEAL) and the gentleman from Ohio (Mr. BROWN) each will control 20 minutes.

The Chair recognizes the gentleman from Georgia (Mr. DEAL).

GENERAL LEAVE

Mr. DEAL of Georgia. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and include extraneous material on H. Res. 669.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Georgia?

There was no objection.

Mr. DEAL of Georgia. Mr. Speaker, I yield myself such time as I may consume.

As we celebrate the 10th anniversary this week of the National Men's Health Week, few topics are more germane than prostate cancer.

This year, 2004, the American Cancer Society estimates that approximately 230,000 new cases of prostate cancer will be diagnosed in our country and that nearly 30,000 men in this country will die from prostate cancer. It is, in fact, the second leading cause of cancer death in men in the United States.

About 16 percent of American men will be diagnosed with prostate cancer during their lifetime, 8 percent will develop significant symptoms, and 3 percent will die of the disease. Over $4.7 billion is spent annually in the United States in direct treatment costs for prostate cancer. African American men are diagnosed with and die from prostate cancer more frequently than men of other ethnic backgrounds.

Increased education among health care providers and patients regarding the need for prostate cancer screening tests has resulted in the diagnosis of approximately 86 percent of prostate cancer patients before the cancerous cells have spread appreciably beyond the prostrate gland, thereby enhancing the odds of successful treatment.

The potential complication rates for significant side effects vary among the most common form of treatment for